Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: The Clinic For Special Surgery 900 12th Ave. Fort Worth, TX 76104	MDR Tracking No.: M4-04-2403-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Protection Insurance c/o FO&L Rep. Box # 39	Date of Injury: Employer's Name: 7 Eleven Inc. Insurance Carrier's No.: 4650154293

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Not paid at usual and customary as ordered 6/18/03 when final judgment was entered in cause GN202229 in District Court of Travis County, 98th Judicial District.

Principle Documentation: 1. TWCC-60
2. EOB
3. UB-92
4. Operative Report

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The billing in dispute has been paid at a fair and reasonable rate.

Principle Documentation: 1. Respondent's response to the initial submission to Dispute Resolution
2. Kemper Reimbursement Methodology

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
10-23-02	Ambulatory Surgical Center Care	1	$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1. This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that the respondent provided persuasive information that supports that their recommended amount is fair and reasonable. The respondent used a methodology that considered varied factors/data and adequately outlines that how the derived reimbursement amount represents a fair and reasonable payment. It does not appear that the requestor provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). Based on the documentation contained in this dispute and both parties' positions, it is clearly evident that the fair and reasonable reimbursement is the amount recommended by respondent.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.1 compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1
28 Texas Administrative Code Sec. 133.307

PART VII: DIVISION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Findings and Decision by:

	Elizabeth Pickle	September 22, 2005
Authorized Signature	Typed Name	Date of Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.